PRINTED: 11/02/2016
FORM APPROVED
Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN4710	A. BUILDING: _____ B. WING _____	10/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC HEALTHCARE, KNOXVILLE	809 EAST EMERALD AVE KNOXVILLE, TN 37917

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments A Licensure survey and complaint investigation #39622 and #39609 was conducted on 10/17/16 through 10/20/16, at NHC Healthcare Knoxville. No deficiencies were cited under Chapter 1200-08-06, Standards For Nursing Homes.	N 000	(This Page is Blank)	

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

T. Bradley Shuford, Administrator — POC#2 — 11/21/16